KENTUCKY BOARD OF SOCIAL WORK

44 Fountain Place, Frankfort, Kentucky 40601 ~ (502)564-2350 ~ http://finance.ky.gov/bsw/

CONTRACT FOR CLINICAL SOCIAL WORK SUPERVISION

APPLICATION INSTRUCTIONS

1. This application is to be used with Microsoft Word.
2. Press the TAB key to skip to the next field.
3. The completed application may be submitted to the Kentucky Board of Social Work by mail 44 Fountain Place, Frankfort, Kentucky 40601.

KENTUCKY BOARD OF SOCIAL WORK (07-2000)

44 Fountain Place
Frankfort KY 40601

CONTRACT FOR CLINICAL SOCIAL WORK SUPERVISION

Instructions:

1. Read the application and instructions carefully before filling out the application. Answer all questions. If the answer is "no" or "none" please indicate. If non-applicable, indicate "N/A". If additional space is needed, attach separate sheets.
2. Please type or print legibly.
3. If experience is from multiple work setting or supervision from more than one supervisor is planned, complete the contract as indicated.
4. **YOU SHALL INCLUDE A CURRENT OFFICIAL AGENCY JOB DESCRIPTION, SIGNED BY THE EXECUTIVE DIRECTOR, HUMAN RESOURCES DIRECTOR, OR AGENCY SUPERVISOR.**

Applicant's Name | CSW License # | Issue Date

Applicant's Address: Street | City | State | Zip Code

Email Address:

PLEASE SELECT THE CATEGORY OF APPROVAL WHICH YOU ARE SEEKING

☐ **Clinical Practice Contract –** a CSW who desires to practice clinical social work which does not qualify as supervised experience shall submit a supervision contract pursuant to KRS 335.080(3) and 201 KAR 23:070 Section 8(c)(2). **Please note: This type of contract does not allow supervision hours to accumulate toward licensure as a LCSW.**

☐ **Pre-Approved Evaluation –** candidates not otherwise exempted under KRS 335.101(3), (4), or (5) shall submit a contract for the experience which will be taking place over the required time period and have the contract approved by the Board prior to beginning supervision. This contract shall be evaluated by the board and shall be approved or disapproved within ninety (90) days of its submission. Any job changes or supervisory changes shall be reported to the Board.

☐ If you have previous supervision hours you wish to submit *(from an agency exempt from Kentucky law or from employment held out of state)* please check and submit the "**Supervised Experience Documentation Form for Licensed Clinical Social Worker" (Part I, II, III)** along with this completed supervision contract form.

CURRENT CLINICAL SOCIAL WORK SETTING

Facility Name | Phone Number

Facility Owner

Does the agency subcontract the mental health component? ☐ Yes ☐ No

If yes, to what entity? _____

Facility Address: Street | City | State | Zip Code

SUPERVISOR OF RECORD

A. Name: _____ KY LCSW License # _____ Original Issue Date _____

B. Address: _____
Street City State Zip Code

C. Telephone: Home: ( ) - _____ Office Phone: ( ) - _____

D. Date of Supervisor Training **(attach copy of certificate):**

E. Email Address: _____

ADDITIONAL SUPERVISOR(S) (If you will be receiving supervision from any other supervisor, please list each one)

1A. Name: _____ KY LCSW License # _____ Original Issue Date _____

1B. Address: _____
Street City State Zip Code

1C. Telephone: Home: ( ) - _____ Office Phone: ( ) - _____

1D. Date of Supervisor Training **(attach copy of certificate):**

1E. Email Address: _____

2A. Name: _____ KY LCSW License # _____ Original Issue Date _____

2B. Address: _____
Street City State Zip Code

2C. Telephone: Home: ( ) - _____ Office Phone: ( ) - _____

2D. Date of Supervisor Training **(attach copy of certificate):**

2E. Email Address: _____

SHARED RESPONSIBILITY FOR SUPERVISION RECEIVED OUTSIDE OF EMPLOYMENT SETTING

If the supervision for the activities listed in this application is to be received outside the applicant's place of employment, the section below shall be completed and signed by the supervisor of record, the applicant, and an authorized person representing the agency.

We the undersigned, do hereby acknowledge the sharing of professional responsibility between _____ (Name of agency) and _____ (Supervisor of record) for the clinical social work service provided to clients of the above named agency by _____ (Applicant) and are jointly to be held accountable for the quality of service provided.

We further acknowledge that since the supervision outlined previously will take place outside the agency of employment and that agency cases will be used in the supervisory relationship, complete and total confidentiality of patient records will be maintained by all parties throughout the period.

Signature of Supervisor of Record Certificate No. Date

Signature of Additional Supervisor (if applicable) Certificate No. Date

Signature of Applicant Certificate No. Date

Signature of Additional Supervisor Agency Representative Date

PLAN OF CLINICAL SOCIAL WORK ACTIVITIES

A. A detailed description of the nature of this practice is: (i.e., what types of activities, therapies, counseling, etc.; will they be individuals, couples, groups, etc.; length and duration of therapy)

B. A detailed description of the nature, duration, and frequency of the supervision in this practice is: (i.e. how often and how long are supervisor sessions; what will be done in supervisory sessions; how will they be conducted)

C. A detailed description of the conditions or procedures for termination of this relationship is:

D. Hours per week spent in direct client-professional relationship. _____ (Include clinical diagnosis and treatment only). This requires eighteen (18) hours for full-time and twelve (12) hours for part-time.

AFFIDAVIT

I, the supervisor of record for the above named candidate for licensure as a licensed clinical social worker, have devised and discussed this plan with the applicant and accept responsibility for its implementation. Further, I understand that upon completion of the plan of supervised activities for clinical social work experience and application for examination, I will be asked to comment on the ethical behavior and therapeutic competency acquired by the applicant. If, for any reason, the conditions of this plan are changed, or this supervisory relationship is terminated or changes, I will immediately notify the board. Further, I do hereby certify that my Kentucky license is current, and will be maintained throughout this period.

Signature of Clinical Supervisor: _____ Date: _____

I, the applicant in the above plan, understand that I will be expected to comply with the provisions of this plan in its entirety and shall notify the Board of any modifications of this plan once it has been approved by them. Failure to do so may result in voiding of the approval given by the Board and loss of supervision hours gained.

Signature of Applicant: _____ Date: _____

AGENCY SUPERVISOR

If the supervision listed in the Plan of Clinical Social Work Activities in this application is provided by someone other than the applicant's agency supervisor, the agency supervisor shall review the proposed plan and sign the statement below:

As agency supervisor of the above named candidate, I affirm the agency will support the proposed practice experience as described in A of this page.

Signature of Agency Supervisor: _____ Date: _____

Note: KRS 335.80 states, "no certified social worker shall enter into a practice of clinical social work until this contract has been approved by the Board."